

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155287		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/27/2012	
NAME OF PROVIDER OR SUPPLIER RENSSELAER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1309 E GRACE ST RENSSELAER, IN 47978			
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00108304 and IN00113834.</p> <p>Complaint IN00108304 Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F333, F425 and F514.</p> <p>Complaint IN00113834 Substantiated. Federal/State deficiencies related to the allegations are cited at F280, F282 and F333.</p> <p>Survey dates: August 20, 21, 22, 23, and 27, 2012</p> <p>Facility number: 000185 Provider number: 155287 AIM number: 100290840</p> <p>Survey team: Marcia Mital, RN, TC Regina Sanders, RN Shannon Pietraszewski, RN (August 20, 21, 22, and 23, 2012)</p> <p>Census bed type: SNF/NF: 90 Total: 90</p>			F0000	<p>This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Census Payor type:</p> <p>Medicare: 14</p> <p>Medicaid: 68</p> <p>Other: 08</p> <p>Total: 90</p> <p>Sample: 18</p> <p>Supplemental sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/31/12 by Suzanne Williams, RN</p>						

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F0176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, record review, and interview, the facility failed to ensure residents had been assessed and determined to be safe to administer their own medication, related to residents being left alone during nebulizer treatments, for 2 of 2 residents observed receiving nebulizer treatments in a supplemental sample of 10. (Residents #13, and #44)</p> <p>Findings include:</p> <p>1) During an observation on 08/23/12 at 11:10 a.m., Resident #13 was observed to be sitting in her room. A nebulizer mask was on the resident and the nebulizer was on and administering the fluid in the plastic reservoir. There were no staff in the resident's room. The nurse on the unit was further down the hall with the medication cart giving medications to other residents. The Core Unit Manager then came from the Nurses Station and walked into the room with Resident #13.</p> <p>During an interview at the time of the observation, the Core Unit Manager indicated the nurse should have stayed</p>		F0176	<p>F 176 1. Corrective action for the residents affected by the alleged deficient practice: Res #13 and #44 had lung assessments completed with no negative outcomes. The Nurse involved was educated by the DON prior to survey exit on the policy and procedure of nebulizer assessment and administration prior to survey exit. No negative outcome was identified by the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents that require a nebulizer treatment have the potential to be affected. Residents receiving Nebulizer treatment services have had their orders reviewed, assessments completed and physicians notified of self administration when appropriate. This will be completed by date of compliance by DON/Designee. The BIMS assessment has been reviewed for those residents who self administer nebulizer treatments to ensure appropriateness of self administration of nebulizer</p>		09/26/2012	

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	<p>with the resident, but she was not sure if the nurse knew she was supposed to. She indicated the resident did not have a self-administration of medication order.</p> <p>Resident #13's record was reviewed on 08/23/12 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia and bronchial pneumonia.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order for Albuterol (breathing medication) 0.083% inhalation solution via nebulizer three times a day. There was a lack of documentation to indicate the resident had an order for self administration of medications.</p> <p>A Social Service progress note, dated 04/05/12, indicated the resident's cognition was impaired.</p> <p>2) During an observation on 08/23/12 at 11:15 a.m., Resident #44 was sitting in her room. A nebulizer mask was on the resident and the nebulizer was on and administering the fluid in the plastic reservoir. There were no staff in the resident's room. The nurse on the unit was down the hall with the medication cart.</p> <p>During an interview at the time of the</p>			<p>treatments per DON/Designee.</p> <p>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: Licensed nursing to be in serviced by DON/Designee on policy and procedure for administering nebulizer treatments. Active nurse will have completed the in service and competency training by Date of compliance. PRN nurses will be completed prior to first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/DESIGNEE will conduct random audits of nebulizer treatments of no less than 2 per day 5 times weekly X 4 week on all units and rotating shifts to ensure proper procedure is followed. Audits will then continue with 10 residents monthly x 3 month, and then 10 residents will be audited quarterly as needed until 95% compliance is achieved. Any Negative patterns will be presented to PI monthly for further review/recommendations.</p> <p>5. 9.26.12</p>			

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	<p>observation, RN #5 (Nurse working the unit) indicated she should have stayed with the resident but she had four nebulizer treatments to do. She indicated she had been told to stay with the residents during the nebulizer treatments.</p> <p>Resident #44's record was reviewed on 08/23/12 at 11:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and Schizoaffective disorder.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order for Albuterol 0.083% inhalation solution every six hours via nebulizer. There was a lack of documentation to indicate the resident had an order for self administration of medications.</p> <p>The Short Portable Mental Status Questionnaire, dated 08/15/12, indicated the resident had moderate intellectual impairment.</p> <p>A facility policy, titled, "Policy for Self-Administration of Medication", dated 10/26/04, received from the ADoN (Assistant Director of Nursing) as current, indicated, "...the interdisciplinary team must assess the residents ability to perform the responsibility..."</p>						

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	3.1-11(a)				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and place interventions to prevent further occurrences of inappropriate behavior in 2 of 18 residents reviewed for care plans (Resident B and Resident C) in a total sample of 18.</p> <p>Findings include:</p> <p>An Unusual Occurrence Report dated 5/24/12 (no time) indicated Resident B and C were both alert and oriented to person, place and time. Resident B and C were observed kissing by a nurse. The nurse observed Resident C's pants pulled</p>		F0280	<p>F 280</p> <p>1. Corrective action for the residents affected by the alleged deficient practice: Resident B and C had their care plans reviewed and updated by Social Service to ensure appropriate behavior care plans were put in place. There were no negative outcomes identified for the alleged deficient practice.</p> <p>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents who have behaviors have the potential to be affected. Prior to survey exit, an audit was conducted to ensure appropriate interventions</p>		09/26/2012	

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	<p>slightly off the waist.</p> <p>A witness statement form dated 5/24/12 at 8:30 a.m. indicated a housekeeper observed Resident B and C kissing in Resident C's room. Resident B was advised to leave the room. Resident C was educated on the inappropriateness of kissing Resident B and was informed of his marital status.</p> <p>A witness statement form dated 5/24/12 at 12:15 p.m. indicated (ineligible signature) spoke with Resident C about his relationship with Resident B. Resident B indicated he likes his time with Resident C; they hold hands and visit in each other's room. Resident B was alert and oriented to person, place and time during the interview and verbalized understanding of the interview.</p> <p>A witness statement form dated 5/30/12 at 4:00 p.m. indicated Social Worker #1 and the Administrator met with Resident B's family regarding the relationship between Resident B and C. Resident B's family indicated they didn't feel comfortable with the relationship. The family requested to speak with Resident B and requested to not share this occurrence with Resident B's spouse. The statement indicated the family would update the Administrator with the result of the conversation with</p>				<p>are care planned for residents who have identified behaviors.</p> <p>3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: The interdisciplinary care plan team will be in serviced by the DON/SSD/Designee on the policy and procedure of writing care plans to ensure appropriate interventions for behaviors are being addressed. PRN staff will be in serviced prior to working first scheduled shift. In servicing to be completed by date of compliance.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur: The SSD will audit 10 behavioral resident care plans weekly x 4 weeks, then 10 residents monthly X 3 months, then 10 residents quarterly as needed until 95% compliance is achieved. Any Negative patterns will be presented to PI monthly for reviews/recommendations.</p> <p>5. 9.26.12</p>		

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	<p>Resident B.</p> <p>A social service note on 5/24/12 (no time) indicated Resident C's friendship with Resident B and they enjoy spending time with each other.</p> <p>A care plan conference summary note on 5/31/12 indicated a meeting with Resident C and her family. The daughter in law indicated the resident "has always been a compassionate 'touchy-feely' person and has never meant it in a bad way...Res. (resident) daughter in law advised [Resident C] to be cautious..." Resident C's daughter in law indicated to Social Worker #1 of the resident's history of being "promiscuous."</p> <p>1. Resident B's record was reviewed on 8/20/12 at 3:00 p.m. Resident B's diagnoses included, but were not limited to, cerebral vascular accident (stroke), dementia, and diabetes mellitus. The 3/19/12 quarterly MDS (Minimum Data Set) Assessment indicated the resident was severely impaired. The 6/13/12 quarterly MDS Assessment indicated the resident was moderately cognitively impaired.</p> <p>Resident B's care plan, initiated on 5/24/12, indicated "I have a female co-resident friend who I enjoy to spend</p>						

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	<p>time with." No interventions were documented of what was put into place to prevent further occurrences.</p> <p>2. Resident C's record was reviewed on 8/20/12 at 12:00 p.m. Resident C's diagnoses included, but were not limited to, dementia, anxiety, and IDDM (insulin dependent diabetes mellitus). The 5/17/12 quarterly MDS Assessment indicated the resident to be severely cognitively impaired. A "Short Portable Mental Status" questionnaire also dated 5/17/12, indicated the resident to have mild cognitive impairment. A "Short Portable Mental Status" questionnaire dated 5/24/12, indicated the resident to be moderately cognitively impaired.</p> <p>Resident C's care plan dated 2/1/12, with an updated target date of 8/30/12, indicated the resident had short term memory loss but was capable of making independent decisions. A care plan dated 2/1/12, indicated the resident was at risk for abuse related to abuse assessment indicating diagnosis of dementia with delusions/psychosis. A care plan dated 5/24/12, indicated "I have a female [sic] co-resident friend who I enjoy to spend time with." No interventions were documented of what was put into place to prevent further occurrences.</p>						

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	<p>The Social Worker #1 was interviewed on 8/21/12 at 11:00 a.m. regarding Resident B and C's interventions. SW #1 had indicated Resident B's family wanted to speak with the resident first and did not want to tell the spouse, because they feared she would stop visiting the resident. SW #1 indicated both residents were placed on 15 minute checks until the IDT (Interdisciplinary Team) met.</p> <p>The Administrator was interviewed on 8/21/12 at 1:30 p.m. and he indicated due to Resident B's family request, the spouse was not informed of the observed relationship and they were going to speak with the resident.</p> <p>The Administrator was interviewed on 8/22/12 at 1:28 p.m. regarding the mental status of Residents B and C at the time of the incident. The Administrator indicated Residents B and C answered questions appropriately when assessing their cognition and he was not aware of their level of cognitive impairment that was documented on the MDS (Minimum Data Set) Assessment. The Administrator indicated Resident C's mental status fluctuates daily. The Administrator verbally indicated the interventions that were put into place but were not documented for the staff to refer to.</p>						

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	This federal tag relates to Complaint IN00113834. 3.1-35(d)(2)(B)						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed related to fluid intake, accucheck (blood sugar checks), and medications for 1 of 18 residents reviewed for following physicians orders in a total sample of 18. (Resident #G)</p> <p>Findings include:</p> <p>Resident #G's record was reviewed on 08/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and chronic renal disease.</p> <p>A) The Physician's Recapitulation orders, dated 08/12 indicated an order dated 02/11/12 to, "push fluids-must drink 1200-1500 cc (cubic centimeters) per day."</p> <p>The Intake totals for 08/12 were as followed: 08/01- 600 cc 08/02- 420 cc 08/03- 1160 cc 08/04- 930 cc</p>			F0282	<p>F 282</p> <p>1. Corrective actions for the residents found to have been affected by the alleged deficient practice: Resident G Had physician notification of alleged failure to follow physician orders related to fluid intake, accu check, insulin administration, and vitamin D administration. This was completed on 08/24/12 by the DON. An intake and output sheet was initiated prior to survey exit. No negative outcome from the alleged deficient practice was noted.</p> <p>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents with orders for specific fluid intake parameters, ordered accu checks, insulin administration and Vitamin D have been audited by nursing administration prior to date of compliance by the Don. No negative outcomes identified by alleged deficient practice.</p> <p>3. Measures/Systemic changes put into place to ensure the alleged deficient practice does not re occur: Licensed nurses will be in serviced by the SDC/DON/DESIGNEE on the</p>		09/26/2012

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	<p>08/05- 1020 cc 08/06- 540 cc 08/07- 450 cc 08/09- 1160 cc 08/10- 610 cc 08/11- 860 cc 08/12- 480 cc 08/13- 1130 cc 08/14- 900 cc 08/16- 600 cc 08/18- 1130 cc 08/19- 1140 cc 08/20- 450 cc 08/21- 300 cc 08/22- 1150 cc</p> <p>During an interview on 08/23/12 at 9:50 a.m., the DoN (Director of Nursing) indicated the facility was not meeting the 1200-1500 cc's of fluid as ordered by the physician.</p> <p>B) The Physician's Recapitulation Orders, dated 08/12, indicated an order originally dated 12/30/11 for Accuchecks Fasting and two hours after meals.</p> <p>The Medication Administration Record (MAR), dated 07/12, indicated the resident's Accuchecks had not been completed on July 2 at 2 p.m., July 10 at 7:30 a.m., July 11 at 10 a.m., July 13 at 2 p.m., and July 18 at 2 p.m.</p>		<p>policy and procedure of following fluid intake parameters, ordered accu checks, insulin and vitamin D administration. In servicing will be completed by date of compliance with PRN in serviced prior to starting first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The SDC/DON/DESIGNEE will conduct audits 5 X weekly for 4 week, of MARs, accu check sheets and Intake and Output records. Audits will then continue 4 X per month X 3 months and then 1X per quarter as needed until 95% compliance is achieved. Any Negative patterns will be presented to monthly PI for review/recommendations.</p> <p>5. 9.26.12</p>				

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	<p>The MAR, dated 08/12, indicated the resident's Accuchecks had not been completed on August 7 at 2 p.m., August 12 at 2 p.m. and 7 p.m., and August 15 at 2 p.m.</p> <p>During an interview on 08/23/12 at 1:25 p.m., ADoN indicated there was no documentation to indicate the Accuchecks had been completed.</p> <p>C) The Physician's Recapitulation Orders, dated 08/12, indicated an order originally dated 06/11/12, indicated an order for Vitamin D2 50,000 units (supplement) every month.</p> <p>The MAR, dated 07/12, indicated the resident received the Vitamin D2 on 07/02 and 07/12.</p> <p>During an interview on 08/23/12 at 1:25 p.m., the ADoN indicated the resident received the Vitamin D2 twice in July.</p> <p>D) The Physician's Recapitulation Orders, dated 08/12, indicated orders originally dated 10/06/11 for Levemir insulin, 12 units at bedtime and 01/04/12 for Novolog insulin, 12 units three times a day with meals.</p> <p>The MAR, dated 07/12, indicated the resident had not received the Levemir</p>						

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	<p>insulin on 07/14/12 at 8 p.m., and Novolog insulin on 07/10/12 at 8 a.m. and 12 p.m., 07/13/12 at 12 p.m., 07/16/12 at 12 p.m., and 07/30/12 at 12 p.m.</p> <p>The MAR, dated 08/12, indicated the resident had not received the Novolog insulin on 08/10/12 at 12 p.m.</p> <p>During an interview on 08/23/12 at 1:25 p.m., the ADoN indicated the insulin had not been given if it was not signed out.</p> <p>This Federal tag relates to Complaints IN00113834 and IN00108304.</p> <p>3.1-35(g)(2)</p>						

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on record review and interview, the facility failed to ensure a resident with a fracture received treatment timely, which caused the resident pain, for 1 of 2 residents reviewed with fractures in a total sample of 18. (Resident #L)</p> <p>B. Based on record review and interview, the facility failed to ensure residents received the necessary care and services related to assessments of a dialysis shunt (access for dialysis) for 1 of 1 resident who received dialysis and assessment/follow up of a resident with a low blood sugar for 1 of 10 residents with diabetes mellitus in a total sample of 18. (Resident #D and #G)</p> <p>Findings include:</p> <p>A. 1. Resident #L's closed record was reviewed on 8/22/12 at 3:10 p.m. Resident #L's diagnoses included, but were not limited to, dementia, hypertension, and osteoporosis.</p>			F0309	<p>F 309</p> <p>1. Corrective action for the residents found to have been affected by the alleged deficient practice: Resident L no longer resides in facility; Resident D had orders obtained to assess the dialysis shunt every shift on 08/25/12 per unit manager and order placed on treatment sheet. Resident G had physician notified of low blood sugar on 08/24/12 by the DON. There were no negative outcomes noted from the alleged deficient practice.</p> <p>2. Corrective action taken for those residents having the potential to be affected by the same alleged deficient practice: Residents that have scheduled x-rays have been audited by nursing administration prior to survey exit. No other residents have a dialysis shunt requiring assessment every shift. Residents with orders for blood glucose monitoring and insulin administration have been audited prior to survey exit by Nursing Administration and no negative outcomes were noted from the</p>		09/26/2012

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	<p>A significant change MDS (minimum data set) assessment, dated 3/9/12, indicated the resident had severe cognitive impairment and required extensive assistance of two staff members for bed mobility, transfers, and toilet use.</p> <p>A nurses' note, dated 4/17/12 at 12 p.m., indicated "MD here to see (sic). N.O. (new order) received et (and) noted...."</p> <p>A physician progress note, dated 4/17/12, indicated "...issues to be addressed...R (right) knee warm, swollen...monitor & elevate R knee..."</p> <p>The nurses' notes indicated: 4/17/12 at 9 p.m., "...R knee notes c (with) trace edema. Elevated knee for comfort..." 4/18/12 at 2:30 p.m., "(Physician name) called @ (at) 1:15 p.m. and message left for nurse concerning R knee edema and pain. Resident grimaces when leg elevated...Passed onto next shift to follow-up since no return call from (physician's name) office..." 4/18/12 at 4:15 p.m., New orders recd (received) per (physician name) for x-ray of R knee d/t (due to) Dx (diagnoses) of pain & edema to area..." 4/18/12 at 8:30 p.m., "(name of x-ray company) here x-ray of knee done- area remains swollen...elevated on pillow</p>		<p>alleged deficient practice.</p> <p>3. Measures/systemic changes put into place to ensure the alleged deficient practice does not re occur: Licensed nurses have been in serviced prior to date of compliance by the DON/DESIGNEE on the policy and procedure regarding assessment of dialysis shunts, Blood Glucose monitoring with pre and post assessments if indicated. In service also included scheduling of ordered X-rays along with obtaining results, receiving results and reporting to MD timely. Requests for X-ray results will be placed on the unit calendar to ensure timely follow up.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/DESIGNEE will audit the treatment administration records to ensure documentation completed on assessments of dialysis shunts. The DON/DESIGNEE will review unit schedule calendars for X ray follow up to ensure results have been received and reported timely. The DON/DESIGNEE will audit the blood glucose records to ensure the documentation of blood sugar results and assessments are completed as indicated. These audits will be completed Monday thru Friday x 4 weeks, then 4 X monthly x 3 months, then 3 X quarterly as needed until 95% compliance. Any negative patterns will be presented to PI monthly for</p>				

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	<p>while in bed- tyl (Tylenol) given earlier for Dx of pain c (with) positive results..." 4/19/12 at 6 p.m., "Rt (right) knee cont (continues) c edema...Res Rt knee elevated in bed..."</p> <p>4/20/12 at 8:30 a.m., "Res (Resident) c facial grimacing during A.M. (morning) care et also grabbing Rt knee. Rt knee continues c edema...Called (Physician's name) office et notified..."</p> <p>4/20/12 at 11:50 a.m., "Rec;d N.O. for...x-ray of Rt knee c (name of x-ray company)..."</p> <p>4/20/12 at 1 p.m., "Called (name of x-ray company) to schedule x-ray of Rt knee. Stated that an x-ray was done on 4/18/12. Asked to fax results."</p> <p>4/20/12 1:10 p.m., "Rec'd results of Rt knee x-ray. Faxed et called (Physician's name) c results of Rt knee x-ray. N.O. to schedule consult c orthopedic doctor at (name of hospital) et have therapy apply long knee brace to leg...Called (hospital name) scheduling to schedule apt (appointment) c orthopedic, stated that she will call back c date et time..."</p> <p>The X-ray report, dated 4/18/12, indicated "...SIGNIFICANT FINDINGS RIGHT KNEE: Two view right knee demonstrates malpositioning on the total right knee prosthesis with respect to the distal femoral...The possible presence of a fracture at this site cannot be</p>				<p>review/recommendations.</p> <p>5. 9.26.12</p>		

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	<p>excluded.....IMPRESSION.....</p> <p>Malpositioning of the total knee prosthesis with respect to the distal femoral. (knee)..This may be due to a fracture..."</p> <p>A physician's order recapitulation, dated 4/12, indicated an order for Tylenol 325 milligrams two tablets every four hours as needed for pain.</p> <p>The resident's MAR (Medication Administration Record), dated 4/12, indicated the resident had received Tylenol for pain on 4/17/12 at 7 a.m. and 4/20/12 at 8:00 a.m. for right knee pain. The MAR lacked documentation of any pain medication administered to the resident on 4/18/12.</p> <p>During an interview on 8/23/12 at 11:15 a.m., LPN #6 indicated she had taken care of resident #L on 4/18/12. She indicated she had documented the note on 4/18/12 at 2:30 p.m. She indicated she had administered Tylenol to the resident when the resident was grimacing in pain, but she had not documented the Tylenol administration on the MAR.</p> <p>A nurses' note, dated 4/21/12 at 10 a.m., indicated "...rec'd order to send to (name of hospital) ER (emergency room) for Eval (evaluation) et tx (treatment)..."</p>						

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	<p>This was three days after the x-ray was ordered.</p> <p>A right knee x-ray, dated 4/21/12, indicated "...Discussion: The study is frontal, lateral and both oblique views. There is...fracture just above the femoral prosthesis. The fracture is offset by at least 50% with the knee lateral to the femoral shaft...IMPRESSION: Distal femoral shaft fracture with displacement."</p> <p>During an interview on 8/22/12 at 3:25 p.m., the ADoN (Assistant Director of Nurses), indicated they should have gotten the x-ray results back before 4/20/12 when it had been done on 4/18/12. She indicated the resident should have gotten pain medication and treatment before the 20th when they got the results of the x-ray. She indicated the resident was sent to the hospital on the 21st.</p> <p>B1. Resident #G's record was reviewed on 08/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and chronic renal disease.</p> <p>The Physician's Recapitulation orders, dated 08/12 indicated an order dated 01/04/12 for Glucagen (medication given for low blood sugar) 1 milligram (mg) as needed for glucose less than 60 after</p>						

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	<p>administration of orange juice if unable to elevate above 70.</p> <p>The Medication Administration Record (MAR), dated 08/12, indicated the Glucagen had been administered on 08/03/12.</p> <p>The MAR and medical record lacked documentation of the blood sugar result and an assessment prior and after administering the glucagon.</p> <p>During an interview on 08/23/12 at 10:45 a.m., the Assistant Director of Nursing (ADoN) indicated the nurse should have written the information on the back of the MAR.</p> <p>B2. Resident #D's record was reviewed on 08/20/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to, end stage kidney disease and shunt in left arm.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order 07/06/12 for dialysis three times a week.</p> <p>The Nurses Notes, Pre/Post Dialysis Checklist, and the MARs lacked documentation to indicate the shunt had been assessed every shift or after the resident had dialysis.</p>						

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	<p>During an interview on 08/20/12 at 3:30 p.m., the Core Unit Manager indicated the shunt is only checked on Monday, Wednesday, and Friday after dialysis. She indicated the the Pre/Post Dialysis checklist forms were not getting filled out.</p> <p>During an interview on 08/21/12 at 1:25 p.m., the DoN (Director of Nursing) indicated she had reviewed the facility's policy and wrote orders to assess the shunt site every shift.</p> <p>The facility policy, dated 12/11/01, titled "Shunt/Fistula Sample Acute Care Plan", received from the DoN as current, indicated, "...Assess shunt site pressure dressing post dialysis every 80 minutes...Check thrill and bruit (vibration) every shift...Assess shunt site for s/s (signs and symptoms) of infection q (every) shift...."</p> <p>3.1-37(a)</p>						

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to follow up on the Registered Dietician's (RD) recommendations to prevent weight loss for 1 of 5 residents reviewed for weight loss in a total sample of 18. (Resident #41)</p> <p>Findings include:</p> <p>Resident #41's record was reviewed on 08/21/12 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia and convulsions.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order 12/19/11 for 2 Cal (high caloric drink) (med-pass) 90 cc (cubic centimeters) three times daily.</p> <p>The resident's weight history indicated the following weights, 06/15/12-151 pounds,</p>			F0325	<p>F 325</p> <p>1. Corrective actions for the residents found to have been affected by the alleged deficient practice: Resident # 41 The physician was notified of weight loss and order obtained to increase 2 cal from 90 ml TID to 120 ML TID prior to survey exit.</p> <p>2. Corrective action taken for those residents having the potential to be affected by this alleged deficient practice: Residents with Dietary recommendations for the month of August 2012 were reviewed by nursing administration to assure no other recommendations were missed and no other residents were affected. No negative outcomes were identified.</p> <p>3. Measures/ Systemic changes put into place to ensure the alleged deficient practice does not re occur: The dietary manager will give the</p>		09/26/2012

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	<p>07/05/12- 149 pounds, 08/03/12- 145 pounds, 08/07/12- 145 pounds.</p> <p>During an interview on 08/21/12 at 1:35 p.m., the Core Unit Manager indicated the resident weight on 08/20/12 was 143.8.</p> <p>The Registered Dietician's note, dated 08/08/12, indicated, "...Recommend increase (arrow up) med pass to 120 cc to TID (three times a day)."</p> <p>There was a lack of documentation to indicate the physician had been notified of the recommendation to increase the med pass. There was a lack of documentation to indicate the resident had the med pass increased as recommended.</p> <p>During an interview on 08/21/12 at 1:25 p.m., the Assistant Director of Nursing indicated the facility has 72 hours to notify the physician of recommendations.</p> <p>A physician's order, date 8/21/12 indicated the resident's physician increased the med pass to 120 cc three times a day.</p> <p>3.1-46(a)(1)</p>				<p>DON/DESIGNEE a copy of the dietary recommendations the following morning after she exits. The DON/Designee will ensure follow up thru change of condition meeting Monday - Friday. Licensed nurses will be in serviced by date of compliance by the DON/DESIGNEE/SDC to assure compliance with dietary recommendations and physician notification. PRN nurses will be in serviced prior to starting first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/DESIGNEE will audit the dietary recommendations weekly x 4, then monthly x 3, and quarterly thereafter until 95% compliance is achieved. Any negative patterns identified will be presented to PI monthly for review/recommendations.</p> <p>5. 9.26.12</p>		

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents on Coumadin were being monitored related to not obtaining and notifying physicians of laboratory test results in a timely manner for 2 of 6 residents reviewed on Coumadin (blood thinner) and 1 of 1 residents on Aranesp (medication for anemia) in a total sample of 18. (Residents G, #26 and #93)</p> <p>Findings include:</p>			F0329	<p>F 329</p> <p>1. Corrective action for the residents found to be affected by the alleged deficient practice: Resident # 93 no longer resides in facility. The PT/INR was located showing MD notification. The lab was missing due to an HP audit that coincided with annual survey. The lab was emailed to ISDH on August 29 th , 2012 Resident #26 had Cardiologist notified of PT/INR results prior to survey exit. New orders were</p>		09/26/2012

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	<p>1. Resident #93's closed record was reviewed on 8/23/12 at 8:30 a.m. Resident #93's diagnoses included, but were not limited to, kidney cancer and history of DVT (deep vein thrombosis) [blood clot].</p> <p>A physician's order, dated 7/9/12, indicated PT/INR (test for blood clotting) weekly times four weeks, and Coumadin (blood thinner) 1 mg (milligrams) daily.</p> <p>The resident's MAR (medication administration record), dated 7/12, indicated the resident had a PT/INR drawn on 7/10/12.</p> <p>The resident's record lacked documentation of the results of the PT/INR from 7/10/12.</p> <p>The resident's nurses' notes, dated 7/10/12 through 7/19/12, lacked documentation of the results of the PT/INR and of the physician being notified of the results of the PT/INR.</p> <p>A care plan, dated 7/5/12, indicated "...anticoagulant tx (treatment) r/t (related to) hx (history) DVT. I'm at risk for abnormal bleeding & bruising...monitor PT/INR per md orders; keep md informed as indicated..."</p>				<p>obtained with no negative outcomes observed.</p> <p>Resident G had physician notified of missing labs.</p> <p>2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice</p> <p>Residents that have labs ordered have the potential to be affected by the same alleged deficient practice. Lab orders have been audited for accuracy, MD and family notification, and proper follow through by nursing administration to assure compliance. No other resident's had noted negative outcome.</p> <p>3. Measures/ changes put into place to ensure the alleged deficient practice does not re occur:</p> <p>The SDC will in service licensed nursing on the policy/protocol for obtaining, reporting to appropriate MD and following up on lab orders by date of compliance. PRN nurses will be in serviced prior to first scheduled work day.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: Nursing administration will audit PT/INR results for residents requiring use of Coumadin and Hemoglobin results for those residents receiving Aranesp twice weekly x 4 weeks, then twice monthly x 3 months, Then 3 X</p>		

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	<p>During an interview on 8/23/12 at 1:30 p.m., the DoN (Director of Nurses) indicated she knew the PT/INR was drawn but she was unable to find where the facility had received the results and the physician had been notified of the results of the PT/INR.</p> <p>2. Resident #26's record was reviewed on 8/21/12 at 10 a.m. Resident #26's diagnoses included, but were not limited to, end stage dementia and atrial fibrillation.</p> <p>A physician's order, dated 8/3/12, indicated "Coumadin 1.5 mg Q (every) Friday. Coumadin 3 mg po (orally) Q Sat (Saturday), Sun (Sunday), M (Monday), T (Tuesday), W (Wednesday), Th (Thursday). Re check (indicated by a check mark) PT/INR 8/16/12."</p> <p>A laboratory test result, for a PT/INR and Digoxin (cardiac medication), dated 7/5/12, indicated as of 6/22/12 the resident's cardiologist would be following the resident's PT/INR results. The resident's PT was 19.5 and INR was 1.9 on 7/5/12.</p> <p>The laboratory test results of the PT/INR, dated 8/16/12 indicated the resident's PT was 38 and the INR was 3.8.</p> <p>Handwritten on the bottom of the form</p>				<p>quarterly as needed until 95% compliance is achieved. Any negative trends will be reviewed in monthly PI meeting.</p> <p>5. 9.26.12</p>		

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	<p>was "faxed 8/16/12."</p> <p>The resident's nurses' notes, dated 8/16/12 through 8/21/12, lacked documentation to indicate the physician had been notified of the PT/INR results from 8/16/12.</p> <p>A care plan, dated 5/24/12, indicated "I'm at risk for complications r/t anticoagulant therapy...monitor labs per md orders: keep md informed as indicated..."</p> <p>During an interview on 8/21/12 at 10:25 a.m., the SC (Special Care) Unit Manager, indicated the laboratory results were faxed on 8/16/12 and they had not had any response from the physician yet. She indicated she did not know if the results had been faxed to the physician of the resident's cardiologist. She indicated she had called the cardiologist office this morning but had not gotten a response yet.</p> <p>During an interview on 8/21/12 at 11:23 a.m., the SC Unit Manager indicated she had received orders to change the resident's Coumadin from the cardiologist.</p> <p>A physician's order, dated 8/21/12 at 11 a.m., indicated "Hold Coumadin 8/21/12 then restart at 3 mg po Q D (day). re check (indicated by a check mark)</p>						

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	<p>8/29/12."</p> <p>3. Resident #G's record was reviewed on 08/23/12 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and chronic renal disease.</p> <p>The Physician's Recapitulation orders, dated 08/12, indicated an order 06/20/12 to do a complete blood count (CBC) every two weeks (includes hemoglobin) and 05/23/12 Aranesp (anemia medication) 40 mcg (micrograms) subcutaneously every two weeks if hgb (hemoglobin) is less than 11.5.</p> <p>The record indicated the resident had a CBC completed on 06/12/12 with a hgb of 9.6 (normal 12-15.3), 07/17/12 with a hgb of 9.7, 7/31/12 with a hgb of 10, and 08/14/12 with a hgb of 10.</p> <p>The MAR, dated 06/12, indicated the Aranesp was given on 06/26/12 with no hemoglobin result obtained.</p> <p>The MAR, dated 07/12, indicated the Aranesp was not given on 07/09/12 and was given 07/23/12 (last hgb obtained on 07/17/12).</p> <p>During an interview on 08/23/12 at 1:25 p.m., the ADoN (Assistant Director of</p>						

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	<p>Nursing) indicated the CBC had not been completed every two weeks from from 06/20/12 through 07/17/12. She indicated the Aranesp had not been given on 07/09/12 and the CBCs had not been completed at the time the Aranesp was scheduled to be given.</p> <p>3.1-48(a)(3)</p>						

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F0333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors related to administering the wrong dose of Heparin (a blood thinner) and not administering medications of Digoxin (cardiac medication) as ordered for 1 of 18 residents reviewed for medications in a total sample of 18. (Resident E)</p> <p>Findings include:</p> <p>1. Resident E's record was reviewed on 8/20/12 at 1:30 p.m. Resident E's diagnoses included, but were limited to, atrial fibrillation, urinary tract infection, and diabetes mellitus.</p> <p>A. The resident's physician's order recapitulation, dated 3/12 and 4/12. indicated Digoxin 125 (micrograms) tablet once a day . Hold if apical pulse was less than 60 and notify the physician. Next to the order was PRN (as needed) which had been marked off, and 9 a.m. with pulse written in.</p> <p>The resident's MAR (medication administration record), dated 3/12, indicated the Digoxin was on a "PRN</p>		F0333	<p>F 333 1. Corrective action for the residents found to have been affected by the alleged deficient practice:Resident E had physician notified of digoxin not given as ordered on 4/26/12 and the wrong heparin dose for IV flush on 05/6/2012. 72 hour charting was initiated and new order received for heparin error. The heparin error was sent to ISDH on 5/6/12. Pharmacy was notified of alleged significant med errors that occurred partially due to their errors. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:Residents who have orders for heparin and digoxin have been audited by nursing administration prior to survey exit to ensure no other discrepancies were noted. No negative outcomes were identified.3. Measures/Systemic changes put into place to ensure alleged deficient practice does not re occur: Licensed nursing staff will be in serviced on the appropriate policy and procedures to include the 7 rights of medication administration by the SDC by date of compliance. The SDC/DESIGNEE will complete med pass competencies on 20 nurses, to include all shifts and units</p>		09/26/2012	

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	<p>Administration Record." The Digoxin was not initialed as administered the entire month of March.</p> <p>The resident's MAR (medication administration record, dated 4/12, indicated the Digoxin was on a "PRN Administration Record." The Digoxin was not initialed as administered from 4/1/12 through 4/26/12 when she was sent to the hospital.</p> <p>A Digoxin blood level laboratory test, dated 4/27/12, indicated the levels was low at less than 0.20; normal range was 0.9-2.0.</p> <p>A physician's order, dated 4/26/12, indicated "Res (Resident) admitted to (name of hospital) Dx (diagnosis): CHF (congestive heart failure)."</p> <p>During an interview on 8/20/12 at 2:55 p.m., the Skilled Unit Manager indicated when the nurse checked the physician's order recapitulation, she should have made sure the MAR had been changed also for the Digoxin. She indicated the Digoxin was documented as PRN and was supposed to have been administered daily.</p> <p>B. Resident E's readmission orders, dated 5/3/12, indicated "...Avelox (an</p>			<p>by 9.26.12. Remaining nurses will have competencies completed on first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur: Digoxin and heparin will be audited by nursing administration or designee for accurate dosage, appropriate placement on MAR and administration 1 X weekly x 4 weeks, 1 X monthly x 3, then 1 X quarterly thereafter until 95% compliance is achieved. Any negative patterns will be presented to PI monthly for review/recommendations. 5. Date of compliance: 09/26/2012</p>			

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	<p>antibiotic) 400 mg/250 ml (milliliters) IVPB (intravenous piggy back) daily x (times) 10 days at 12 p.m., and Maxipime (antibiotic) 2 G (grams) IVPB daily x 10 days at 6 p.m. (for pneumonia) ...Coumadin (blood thinner) 5 mg...at 5 p.m....PT/INR (test for blood clotting) weekly x 4 ..."</p> <p>A physician's order, dated 5/3/12, indicated "Midline Catheter (Intravenous access)...Flushing orders...5 ml NS (normal saline) Before Med. 5 ml NS After Med. Then : 3 ml Heparin (blood clotting medication) 10 units/ml.</p> <p>The resident's nurses' notes indicated: 5/3/12 at 12 p.m., "...cont (continues) on IV ABT (antibiotics)..." 5/4/12 at 12 p.m., "...Res on IV abt/pneumonia. Mid -line l (left) upper arm s (without) s/s (signs and symptoms) of infection..." 5/5/12 at 12:30 p.m., "PT/INR (blood clotting tests) checked (indicated by a check mark) c (with) facility machine. Results PT=83.9, INR =7.0...N.O. (new order) to hold Coumadin x 5 day (sic) then re check (indicated by a check mark). Notify MD c results for further orders..." 5/5/12 at 2:00 p.m., "Continues c IV ABT..." 5/5/12 at 8 p.m., "Resident c midline to LUE (left upper extremity) c blood return</p>						

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	<p>when flushed, c multiple bruises L arm..." 5/6/12 at 6 a.m., "...LUE c midline intact and flushes well c blood return..." 5/6/12 at 11 a.m., "Resident had 2 emesis since 8 a.m. Resident called this writer to room et (and) asked to shut door. This writer shut door et Resident lifted up her shirt & Res RT (right) side upper (indicated by an arrow) quad (quadrant) was distended & hard." 5/6/12 at 11:15 a.m., "This writer had wkend (weekend) manager come to room et at that time noticed Lt (left) arm to be bruised dark purple from arm pit to wrist. Bruise was not noticed until this time. Head to toe assessment done...Also noted at this time med (medication) discrepancy..." 5/6/12 at 4 p.m., "(late entry for 5/6/12 1:00 p.m.) Vit (vitamin) K (medication to help blood clot) 10 mg po et Vit K 10 mg IM (Intramuscular) pulled from EDK (emergency drug kit) et given at this time...Coumadin remains on hold..."</p> <p>A physician's order, dated 5/6/12 at 12 p.m., indicated "increased (indicated by an arrow) Bruising give vit K 10 mg po x 1 et Vit K 10 mg IM x 1 now."</p> <p>During an interview on 8/20/12 at 3:17 p.m., the ADoN (Assistant Director of Nurses) indicated the pharmacy had sent Heparin 100 units per milliliter instead of</p>						

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	<p>the Heparin 10 units per milliliter as ordered. She indicated the label on the package indicated it was Heparin 10 units per milliliter. She indicated the nurse who worked on 5/6/12 caught the error because the syringe indicated it was 100 units per milliliter not the 10 units as ordered.</p> <p>During an interview on 8/20/12 at 3:50 p.m., the ADoN indicated the resident had received the wrong dose of Heparin since the order had been received on 5/3/12 with the flushes after the IV antibiotics were administered. She indicated the dose of 100 units per milliliter was on the syringe. (The flushes were done twice a day at 12 p.m. and 6 p.m. with the administration of the IV antibiotics).</p> <p>This Federal tag relates to Complaints IN00113834 and IN00108304.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>						

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F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>A. Based on record review and interview, the facility failed to ensure the pharmacy sent the correct medication, which resulted in the resident getting 100 units of heparin per milliliter instead of the 10 units per milliliter as ordered, which resulted in extensive bruising to a resident, for 1 of 18 residents reviewed for pharmacy medication errors in a total sample of 18. (Resident E)</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure multidose vials of insulin, influenza vaccine, and tuberculin (used for</p>			F0425	<p>F 425 1. Corrective action for the residents found to have been affected by the alleged deficient practice:Resident E had the MD/family notified of medication error, facility observed resident every shift x 72 hours for any negative outcomes and new orders were received. MD reviewed medication error, facility followed policy and protocol by reporting to the ISDH on 05/7/2012. All identified expired medications were immediately taken out of stock. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:Residents who require</p>		09/26/2012

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	<p>tuberculosis testing) were dated when opened and/or discarded when expired, failed to ensure stock medications were discarded when expired, and failed to ensure residents' medications were discarded when the medications were expired, discontinued, or the resident was discharged from the facility for 3 of 3 medication rooms, 5 of 7 Medication Carts, and 1 of 1 Central Supply Room. (Skilled, Core, and Special Unit)</p> <p>Findings include:</p> <p>A. 1. Resident E's record was reviewed on 8/20/12 at 1:30 p.m. Resident E's diagnoses included, but were limited to, atrial fibrillation, urinary tract infection, and diabetes mellitus.</p> <p>Resident E's readmission orders, dated 5/3/12, indicated '...Avelox (an antibiotic) 400 mg/250 ml (milliliters) IVPB (intravenous piggy back) daily x (times) 10 days at 12 p.m., and Maxipime (antibiotic) 2 G (grams) IVPB daily x 10 days at 6 p.m. {for pneumonia} ...Coumadin (blood thinner) 5 mg...at 5 p.m....PT/INR (test for blood clotting) weekly x 4 ..."</p> <p>A physician's order, dated 5/3/12, indicated "Midline Catheter (Intravenous access)...Flushing orders...5 ml NS</p>		<p>heparin medication have the potential to be affected therefore an audit was completed by nursing administration prior to survey exit. Audit consisted of validating orders from medication sheets to labels to assure compliance. No other residents were affected. The medication rooms, central supply, and medication carts had all expired medications and treatments removed on 08/22/2012. The central supply clerk was educated prior to exit on appropriate rotation of medications. 3. Measures/Systemic changes put in place to ensure the alleged deficient practice does not re occur:</p> <p>SDC to in service licensed nursing prior to date of compliance on the appropriate 7 rights of medication pass to include always validating appropriate medication dose. In-servicing to include observing for expiration dates with medication pass and to pull expired medications and treatments off carts. The SDC/DESIGNEE will complete med pass competencies on 20 nurses, to include all shifts and units by 9.26.12. All other nurses will have competencies completed on first scheduled shift.</p> <p>4. Corrective actions will be monitored to ensure the alleged deficient practice does not re occur:</p> <p>The DON/Designee will conduct audits of heparin dosages and expired</p>				

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	<p>(normal saline) Before Med. 5 ml NS After Med. Then : 3 ml Heparin (blood clotting medication) 10 units/ml.</p> <p>The resident's nurses' notes indicated:</p> <p>5/6/12 at 11 a.m., "Resident had 2 emesis since 8 a.m. Resident called this writer to room et (and) asked to shut door. This writer shut door et Resident lifted up her shirt & Res RT (right) side upper (indicated by an arrow) quad (quadrant) was distended & hard."</p> <p>5/6/12 at 11:15 a.m., "This writer had wkend (weekend) manager come to room et at that time noticed Lt (left) arm to be bruised dark purple form arm pit to wrist. Bruise was not noticed until this time. Head to toe assessment done...Also noted at this time med (medication) discrepancy..."</p> <p>5/6/12 at 4 p.m., "(late entry for 5/6/12 1:00 p.m.) Vit (vitamin) K (medication to help blood clot) 10 mg po et Vit K 10 mg IM (Intramuscular) pulled from EDK (emergency drug kit) et given at this time...Coumadin remains on hold..."</p> <p>A physician's order, dated 5/6/12 at 12 p.m., indicated "increased (indicated by an arrow) Bruising give vit K 10 mg po x 1 et Vit K 10 mg IM x 1 now."</p> <p>During an interview on 8/20/12 at 3:17</p>				<p>medications (to include medications being dated when opened, discarded when expired and discontinued or when the resident discharges from facility) 1X weekly X 4 weeks, 1 X monthly x 3 months, then 1X quarterly thereafter until 95% compliance. Any negative patterns will be presented to the monthly PI.5. 9.26.12</p>		

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	<p>p.m., the ADoN (Assistant Director of Nurses) indicated the pharmacy had sent Heparin 100 units per milliliter instead of the Heparin 10 units per milliliter as ordered. She indicated the label on the package indicated it was Heparin 10 units per milliliter. She indicated the nurse who worked on 5/6/12 caught the error because the syringe indicated it was 100 units per milliliter not the 10 units as ordered.</p> <p>During an interview on 8/20/12 at 3:50 p.m., the ADoN indicated the resident had received the wrong dose of Heparin since the order had been received on 5/3/12 with the flushes of after the IV antibiotics were administered. She indicated the dose of 100 units per milliliter was on the syringe. (The flushes were done twice a day at 12 p.m. and 6 p.m. with the administration of the IV antibiotics).</p> <p>B. During an observation of the Medication Rooms and Medication Carts on 08/22/12 at 8:15 a.m. through 9:10 a.m., with the ADoN (Assistant Director of Nursing), the following was observed:</p> <p>1. The Core Medication Room had an unopened bottle of Simethicone tabs (antacid) with an expiration date of 03/12, an opened, unlabeled bottle of antacid chewable tablets, three bottles of mineral</p>						

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	<p>oil (laxative) with expiration dates of 01/12 and 07/12, a opened bottle of Refresh eye drops with an expiration date of 03/12, and a box of Lidoderm patches (pain patch), with an expiration date of 04/12.</p> <p>During an interview at the time of the observation, the ADoN indicated the Simethicone and antacid chewable tables were house stock and the Central Supply Clerk stocks the medication room and should check for expiration dates.</p> <p>During an interview on 08/22/12 at 11 a.m. the ADoN indicated the Refresh eye drops belonged to a resident who had passed away on 06/09/12 there was not an order for the Lidoderm patches since 02/12.</p> <p>The South Wing medication carts (two carts on the wing) had an opened bottle of Phenergan (antiemetic) with an expiration date of 04/12. The carts had two open vials of Lantus insulin opened on 06/03/12 and 07/12/12, Humulin R insulin opened 07/17/12, Novolog insulin opened 07/11/12, and two opened vials Lantus insulin which were not marked with a date they were opened.</p> <p>During an interview at the time of the observation, the ADoN indicated the</p>						

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	<p>insulin should be discarded 30 days after it is opened.</p> <p>The West Wing medication carts (two carts on the wing) there were an opened bottle of Lantus insulin opened 07/01/12 and one opened bottle of Novolog insulin which were not marked with a date it was opened.</p> <p>B.2. The Central Supply Storeroom had two unopened bottles of Simethecone with expiration dates of 03/12, three unopened bottles of Gas Relief (antacid) with expiration dates of 07/12, three unopened bottles of Sorbital (laxative) with expiration dates of 12/11, two bottles of geritussin (cough syrup) with expiration dates of 10/11, and three bottles of tussin DM (cough syrup) with expiration dates of 11/10, 7/11, and 8/11. The expired bottles of medications were found in the back of the shelf where the bottles were stored.</p> <p>During an interview at the time of the observation, the Central Supply Clerk indicated the Pharmacy does not check the Central Supply Storeroom when they come in. She indicated she rotates the stock of medication every month and checks expiration dates.</p> <p>B. 3. The Skilled Unit Medication Room</p>						

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	<p>had two vials of influenza vaccine with expiration dates of 05/12 and one opened vial of tuberculin with an opened dated of 05/10/12 in the refrigerator, and three opened bottle of Cal-gest (antacid) with expiration dates of 10/11, 11/11, and 12/11.</p> <p>During an interview at the time of the observation, the ADoN indicated the tuberculin was only good for 30 days after opening. She indicated the medications should have been discarded.</p> <p>The Skilled Unit Medication cart had two bottles of Novulog insulin with opened dates of 07/21/12.</p> <p>B. 4. The Special Care Medication Room had an unopened bottle of mineral oil with an expiration date of 01/12, there were 3 of 18 vials of lorazepam (antianxiety), which did not have dates of when they were opened and there was an opened bottle of Multivitamins with an expiration date of 01/12.</p> <p>During an interview at the time of the observation, the ADoN indicated the date the vials were opened should have been documented.</p> <p>Review of the facility's policy, titled, "Policy and Procedure for Over the</p>						

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	<p>Counter Medication", dated 04/02/05, and received from the ADoN as current indicated, "...2...be sure that the dosing instructions and expiration date remain legible...Remember that you should rotate you OTC (over the counter) stock by first in, first out checking expiration dates...If expired they must be removed and destroyed per procedure..."</p> <p>A facility policy, titled, "Discontinued Medication", dated 01/01/05, received from the ADoN as current indicated, "...Medication that is discontinued per physician's order must be either returned to pharmacy for credit or destroyed according to regulations in a timely manner (usually within seven days)..."</p> <p>An undated facility policy, titled, "Medication Destruction", received as current from the ADoN on 08/22/12 at 11 a.m., indicated, "...Discontinued medications and medications left in the facility after resident's discharge, if not qualifying for return to the pharmacy for credit, are destroyed..."</p> <p>A list, titled, "Storage Recommendations", dated 03/27/12, and received from the ADoN as current, indicated, "...Tubersol Injection (tuberculin test)...Date when opened and discard unused portion after 30</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	<p>days...Influenza Vaccine...Opened multi-dose vials...may be used until the expiration date...Humalog...opened 28 days...Humulin...opened 28 days...Lantus...opened 28 days...Novolog...opened 28 days..."</p> <p>This Federal tag relates to Complaint IN00108304.</p> <p>3.1-25(g)(1) 3.1-25(m) 3.1-25(o)</p>						

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F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on observation, record review and interview, the facility failed to</p>		F0441	F 441 1. Corrective action for the residents found to have been		09/26/2012	

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	<p>designate an area for handwashing in the dining room away from clean dishes and food being served from the steam table during meals. This had the potential to affect approximately 60 residents in the attached North and South dining room.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure hands were being washed/sanitized, and/or gloved before and after resident contact during medication pass for 1 of 10 supplemental sample residents, and failed to ensure the staff was educated on disinfecting the glucose monitoring machine after each resident use in accordance with manufacturer's instructions for 2 of 2 residents observed receiving blood sugar testing. (Resident #28, #67 and #7)</p> <p>C. Based on record review and interview, the facility failed to ensure residents received yearly mantoux testing (tuberculosis skin test) for 1 of 18 residents reviewed for mantoux testing in a total sample of 18. (Resident #73)</p> <p>Findings include:</p> <p>A1. On 8/20/12 at 12:00 p.m., 8 staff members were observed washing their hands at a sink where clean dishes and a steam table with food being served to the</p>				<p>affected by the alleged deficient practice: Staff was immediately diverted from kitchenette sink when observed by Executive Director. For residents 28, 67 and 7 LPN #2 was educated on hand washing and the appropriate procedure for disinfecting glucometers between use by the SDC prior to survey exit. Resident # 73 had a PPD placed by the unit manager prior to survey exit. No negative outcomes were noted from the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice :Residents who receive medications and accuchecks have the potential to be affected. The SDC and nursing administration observed staff with hand washing and the disinfecting of glucometers. This was completed prior to exit. Audit of required PPD's for residents was completed prior to exit, by nursing administration with no other residents affected. A sign was placed at the kitchenette where the alleged hand washing episode occurred that gives instructions on where to wash hands. 3. Measures/Systems changes put into place to ensure the alleged deficient practice does not re occur:The SDC will in service appropriate staff on the policy and protocol for disinfecting glucometers between use and hand washing with medication</p>		

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	<p>residents was located. Water was observed to be splashing onto the plates and on the steam table.</p> <p>On 8/22/12 at 10:05 a.m., LPN #3 was interviewed and indicated she did not know there was a separate sink to wash hands. She was informed in the morning meeting to use the sink in the Activity Director office adjacent to the dining room.</p> <p>On 8/22/12 at 10:30 a.m., CNA #1 was interviewed and she indicated no one had told her to use a different sink other than the one located in the dining room next to the dishes and steam table. She further indicated the she would need to go down the hall to wash her hands.</p> <p>B1. On 8/20/12 at 4:45 p.m., LPN (Licensed Practical Nurse) #2 was observed preparing Resident #28's medications. LPN #2 had to retrieve medications from the EDK (Emergency Drug Kit) down the hall. Upon returning to the medication cart, the LPN did not wash or sanitize her hands before preparing medications and giving them to the resident.</p> <p>After the medication was given to Resident #28, LPN #2 went to Resident #67's room for a blood sugar check. LPN</p>				<p>pass and between meals. The SDC will in service licensed staff by date of compliance on the policy and protocol for administering, reading and documenting PPDS. PRN nurses to be in serviced prior to beginning of first scheduled shift.4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur:</p> <p>The SDC/DON/Designee will audit 5 nurses weekly to ensure proper hand washing protocol is followed, on all shifts and units, during medication pass and disinfecting glucometers to include competency checks x 4 weeks, then 4 nurses monthly x 3 months, then 3 nurses quarterly thereafter until 95% compliance achieved. The ED will audit 4 meals (to include all meal services) weekly x 4 weeks, 4 meals monthly x 3 monts, then 3 meals quarterly thereafter until 95% compliance achieved to assure appropriate hand washing protocol is being followed. The DON/DESIGNEE will audit 10 charts weekly x 4 weeks, then 10 charts monthly x 3 months, then 10 X quarterly thereafter to assure PPDs are being administered, read, and documented timely. Any Negative patterns identified will be taken to monthly Pl.</p> <p>9.26.12</p>		

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	<p>#2 did not wash or sanitize her hands before applying gloves. After the failed blood stick, LPN #2 was observed removing her gloves. She did not wash her hands nor sanitize them before returning to the medication cart. Upon returning to the room, she did not wash or sanitize her hands before applying gloves. Upon completing the blood sugar check from Resident #67, LPN #2 was observed removing her gloves and returned to the medication cart to obtain Sani-wipes (disinfecting wipes). LPN #2 had gone back to Resident #67's room and placed a band-aid on Resident #67's hand. LPN #2 then applied gloves, and lightly wiped the glucose monitoring machine. She was observed at that time to have washed her hands.</p> <p>Upon leaving Resident #67's room, LPN #2 was observed going to Resident #7's room with the medication cart. LPN #2 had put on gloves, lightly cleaned the glucose monitoring machine and was attempting to obtain a blood sugar check before she was stopped. During this time, LPN #2 was interviewed regarding the proper procedure for disinfecting the glucose monitoring machine. She indicated she had always done it this way and was not aware of the proper procedure for disinfection. During this time, the DON (Director of Nursing)</p>						

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	<p>reviewed the label on the Sani-wipes container and indicated she will need to speak with the SDC (Staff Development Coordinator). After disinfecting the glucose monitoring machine, LPN #2 obtained the blood sugar check from Resident #7. She removed her gloves and had returned to the medication cart to draw up the insulin. During this time, she was observed walking to the medication room down the hall to obtain syringes. Upon returning to the medication cart, LPN #2 was observed removing insulin from the drawer, drawn up the insulin in a syringe and administered the insulin without washing or sanitizing her hands and applying gloves. After disinfecting the glucose monitoring machine, LPN #2 had returned to the medication cart to prepare medications without washing or sanitizing her hands.</p> <p>A policy for "Hand Hygiene" dated 8/2011 was provided by the DON on 8/20/12 at 5:20 p.m. The policy indicated "When hands are visibly dirty or contaminated with proteinaceous material or are visibly soil with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical</p>						

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	<p>situations other than those listed under 'Handwashing' above..."</p> <p>A policy for "Cleaning and Disinfection of the Glucometer" dated 03/10 was provided by the DON on 8/20/12 at 5:20 p.m. The policy indicated ...Pick up the glucometer from the first barrier and disinfect it with a Super Sani Cloth wipe...Allow enough time to dry per the manufacturer's instructions. (Example, Sani-Cloth products dry in two minutes..."</p> <p>A Manufacturing booklet for the Optium EZ Blood Glucose Monitoring System dated 2009 indicated for health care professionals for follow their facility infection control policies and procedures.</p> <p>A policy for "Medication Administration" dated 10/04 was provided by SDC on 8/21/12 at 2:50 p.m. The policy indicated to "follow the hand hygiene protocol before and after each administration of medication."</p> <p>The manufacturing instructions for the Sani-Cloth Bleach Germicidal Disposable Wipes was provided by the ADON on 8/22/12 at 3:00 p.m. The instructions indicated "To Clean, Disinfect and Deodorize: ...Treated surface must remain visibly wet for a full four (4) minutes and let dry..."</p>						

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	<p>An interview with LPN #3 on 8/22/12 at 10:05 a.m. indicated she was not aware of the protocol of disinfecting the glucometer until that morning.</p> <p>An interview with SDC on 8/22/12 at 4:00 p.m., she indicated she was going by the facility's regulations and the products has been changed several times in the last several months. She indicated the staff had not been educated on the Sani-wipes and she is working on an outdated policy.</p> <p>C.1. Resident #73's record was reviewed on 08/20/12 at 12:55 p.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The resident was admitted into the facility on 03/11/10.</p> <p>The "RESIDENT TB (tuberculosis) SCREENING AND IMMUNIZATION RECORD" indicated the TB screening should be completed yearly. The form indicated the resident's last TB screen had been completed on 03/06/11.</p> <p>During an interview on 08/20/12 at 1 p.m., LPN #1 indicated the yearly TB screening had not been completed.</p> <p>3.1-18(b) 3.1-18(l)</p>						

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F0514 SS=E	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate related to medications and physician's orders for 4 of 18 residents in a total sample of 18 (Residents #D, #F, #H, and #L) and 2 residents in a supplemental sample of 10 (Residents #J and #K), who were reviewed for medications and physician's orders.</p> <p>Findings include:</p> <p>1. Resident L's closed record was reviewed on 8/22/12 at 3:10 p.m. Resident L's diagnoses included, but were not limited to, dementia, hypertension, and osteoporosis.</p> <p>A physician's order recapitulation, dated</p>		F0514	<p>F 514 1. Corrective action for residents found to have been affected by the alleged deficient practice:Residents D, F, H, L, J and K had their medication sheets reviewed and no negative outcome were noted. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:Residents that have medications ordered have the potential to be affected. A medication and treatment reconciliation form was instituted for oncoming and off going nurses prior to survey exit. 3. Measures/Systemic changes put into place to ensure the alleged deficient practice does not re occur:Nursing staff will be educated by the DON/DESIGNEE on the new protocol that the oncoming nurse must review medication and treatment books</p>		09/26/2012	

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	<p>4/12, indicated an order for Tylenol 325 milligrams two tablets every four hours as needed for pain.</p> <p>The resident's nurses' notes indicated on 4/18/12 at 2:30 p.m., "(Physician name) called @ (at) 1:15 p.m. and message left for nurse concerning R knee edema and pain. Resident grimaces when leg elevated...Passed onto next shift to follow-up since no return call from (physician's name) office..."</p> <p>The resident's MAR (Medication Administration Record), dated 4/12, lacked documentation of any pain medication administered to the resident on 4/18/12.</p> <p>During an interview on 8/23/12 at 11:15 a.m., LPN #6 indicated she had taken care of resident L on 4/18/12. She indicated she had documented the note on 4/18/12 at 2:30 p.m. She indicated she had administered Tylenol to the resident when the resident was grimacing in pain but, she had not documented the Tylenol administration on the MAR.</p> <p>2. Observation during a medication administration pass on 8/21/12 at 8:55 a.m., LPN #4 was observed administering medications to Resident #K. LPN #4 administered Reglan 5</p>				<p>for omissions prior to taking the keys to the medication cart. Nurses must sign the log to assure this practice is being done every shift. PRN nurses will be educated and in serviced prior to the first shift scheduled. SDC will in service licensed nurses on the policy and protocol for omissions/corrections on the MAR and TAR by date of compliance. 4. Corrective actions will be monitored to ensure the alleged deficient practice will not re occur: The DON/DESIGNEE will conduct medication and treatment sheet audits 5 X per week x 4 weeks, then 4 X per month X 3 months, then 3 X quarterly as needed until 95% compliance is achieved. Any negative patterns will be presented to PI monthly for further review and recommendations. 5. 9.26.12</p>		

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	<p>milligrams to the resident.</p> <p>Resident K's record was reviewed on 8/21/12 at 9:30 a.m. Resident K's diagnoses included, but were not limited to, GERD (Gastric esophageal reflux disease) and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The resident's MAR, dated 8/12, indicated the Reglan 5 milligrams had been ordered twice a day on 7/31/12.</p> <p>The resident's record lacked documentation of a telephone physician's orders dated 7/31/12 for the order for the Reglan 5 milligrams BID.</p> <p>During an interview on 8/21/12 at 9:30 a.m., the Skilled Unit Manager indicated she was unable to find the telephone order for Reglan. She indicated she knew there was an order but she was not able to find it.</p> <p>During an interview on 8/21/12 at 10:20 a.m., the Skilled Unit Manager indicated she had gotten the order faxed over from the Physician for the 7/31/12 Reglan order from the Physician's office file. She indicated she was placing the order in the chart now.</p> <p>3. During an interview on 8/22/12 at 9:43</p>						

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	<p>a.m., the Core Unit Manager, indicated she audits the MAR for not being complete and then let the staff know where they had not signed. She indicated she completed the audits once a month to let the staff know they needed to pay attention.</p> <p>Review of an undated handwritten document, titled, "MAR Holes" (medications not signed out), indicated Resident #J had holes in the MAR on 4/27/12 at 8 a.m. and 12 p.m.</p> <p>Review of Resident #J's MAR, dated 4/12, indicated there were not any holes for 4/27/12 at 8 a.m. and 12 p.m.</p> <p>During an interview on 8/22/12 at 10 a.m., the Core Unit Manager, indicated the nurse who worked that day must have just initialed the MAR for the medications on 4/27/12. She indicated the nurse should have made a late entry for medication administration.</p> <p>During an interview on 8/22/12 at 10:05 a.m., the DoN (Director of Nurses) identified the handwritten form as an internal tool. She indicated the nurses should have documented as late entry if they went back and documented on the MAR. She indicated she would have to do some education with the nurses.</p>						

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	<p>4. Resident #F's record was reviewed on 08/21/12 at 1:15 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus.</p> <p>The Physician's Recapitulation Orders, dated 08/12, indicated an order, originally dated 07/27/10 for weekly weights on Friday.</p> <p>Review of an undated handwritten document, titled, "MAR Holes", indicated Resident #F did not have weights documented on the MAR on 4/14/12 and 4/28/12. Next to the dates were check marks with "done" written.</p> <p>Resident F's MAR, dated 4/12/12, indicated the resident's weight on 4/14/12 was 169.6 pounds and on 4/28/12 was 167.7 pounds. The MAR indicated LPN #7 was who had initialed the weights on 4/14/12 and 4/28/12</p> <p>During an interview on 8/22/12 at 1:05 p.m., LPN #7 indicated she could not say if she had gone back and documented resident F's weights on the MAR on 4/14/12 and 4/28/12.</p> <p>5. Resident #D's record was reviewed on 08/20/12 at 2:45 p.m. The resident's diagnoses included, but were not limited to end stage kidney disease and shunt in</p>						

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	<p>left arm.</p> <p>The MAR, dated 08/12, indicated an order on 07/05/12 for a Flector Patch (pain patch) 1/2 patch to bilateral knees and one patch to the right shoulder. The MAR indicated to put the patches on at 5 a.m. and take them off at 5 p.m. The MAR indicated the area for applying the patches had been left blank on August 8, 11, 12, and 16, 2012 and indicated the patches had been removed on August 8, 11, 12, and 16, 2012.</p> <p>During an interview on 08/20/12, the Core Unit Manager indicated the MAR had been left blank on those days.</p> <p>6. Resident #H's record was reviewed on 08/23/12 at 11 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and anemia.</p> <p>The MAR, dated 08/12, indicated the resident received vitamin B12 once a week. The MAR was left blank on 08/12/12 when the vitamin was scheduled to be given.</p> <p>During an interview on 08/23/12 at 2:05 p.m., the Assistant Director of Nursing indicated comparing what the pharmacy had sent, the resident had received the vitamin B12 and the nurse did not initial</p>						

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	<p>it as given.</p> <p>This Federal tag relates to Complaint IN00108304.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						